



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LISA PERSYN MD
3100 TIMMONS LANE #250
HOUSTON TX 77027

Respondent Name

TPS JOINT SELF INS FUNDS

Carrier's Austin Representative

Box Number 11

MFDR Tracking Number

M4-13-0599-01

MFDR Date Received

NOVEMBER 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in a requestor letter to the respondent: "PER YOUR EXPLANATION OF BENEFITS, IT STATES THAT THE CPT CODES OF 95900, WHICH IS A MOTOR NERVE CONDUCTIONS STUDY, AND THE CPT CODE OF 95904, WHICH IS A SENSORY NERVE CONDUCTIONS STUDY ARE BUNDLED CPT CODES. THIS IS INCORRECT! THEY ARE COMPLETELY DIFFERENT PROCEDURES AND ARE REIMBURSEABLE CHARGES."

Amount in Dispute: \$808.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2012	NCV Testing	\$808.60	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out fee guidelines for professional services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 330 – CCI Comprehensive/Component procedure.
 - 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.
 - 601 – Per the fee schedule, this service or supply is considered bundled.
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has

already been adjudicated.

Issues

1. Did the requestor bill codes that components of another procedure billed on the same date of service?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed Nerve Conduction Studies CPT Codes 95861, 95900 and 95904 on May 23, 2012. In accordance with 28 Texas Administrative Code §134.203(b)(1) for coding, billing, reporting and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the Medicare payment policies, including its coding, billing, correct coding initiatives (CCI) edits and modifiers. The insurance carrier denied payment for CPT Codes 95900 and 95904 using denial code 236 – “This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding initiative” and 330 – “CCI Comprehensive/Component procedure.” Review of NCCI edits finds that both CPT Codes 95900 and 95904 have a CCI conflict with CPT Code 95861; furthermore, according to CMS CCI edits a modifier is allowed, however, review of the CMS-1500 finds that no modifier was used. The effective date for these NCCI edits is January 1, 2012. For these reasons reimbursement is not recommended.

The requestor also billed HCPCS Code A4556 – Electrodes. According to CMS the Medicare rules for this particular code are that it is a bundled/excluded code. For this reason reimbursement is not recommended.

2. Therefore, pursuant to 28 Texas Administrative Code §134.203, the requestor in this medical fee dispute is not due reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 28, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.